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No. 60554-2-I

COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

OVERLAKE HOSPITAL ASSOCIATION and
OVERLAKE HOSPITAL MEDICAL CENTER

and

KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2,
d/b/a EVERGREEN HEALTHCARE,

Respondents,

vs.

DEPARTMENT OF HEALTH OF THE STATE OF WASHINGTON

and

SWEDISH HEALTH SERVICES,

Petitioners

SWEDISH'S PETITION FOR REVIEW

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A. Identity of Petitioner

Swedish Health Services d/b/a Swedish Medical Center ("Swedish") petitions for the relief set forth below.

B. Court of Appeals Decision

Swedish petitions for review of the published decision terminating review (the "Decision"), entered on October 13, 2008, by Division I of the Court of Appeals. A copy of the Decision is attached as Exhibit A of the Appendix to this Petition. Swedish and the Washington State Department of Health (the "Department") timely moved for reconsideration of the Decision, which the Court of Appeals denied on December 29, 2008. A copy of the order denying reconsideration is attached as Exhibit B of the Appendix. On December 30, 2008, the Court of Appeals ordered that the Decision would be published. A copy of the order publishing the Decision is attached as Exhibit C of the Appendix.[1]

C. Statement of Issues Presented for Review

The Decision raises two issues warranting Supreme Court review:

[1] The Decision is now reported at 146 Wn. App. 1074. However, Swedish will cite to the Decision in the slip opinion form originally issued on October 13, 2008 and attached as Exhibit A.

1. By Failing to Accord Substantial Deference to the Department of Health's Interpretation of WAC 246-310-270(9), the Court of Appeals Has Abrogated the Department's Policy, and Longstanding Washington Law, Regarding When and Where New Ambulatory Surgical Facilities Can Be Built.

As this Court recently reaffirmed, "in certificate of need cases" courts must accord "substantial deference" to the Department of Health's interpretation of its regulations, particularly where the Department's "special knowledge and expertise" is involved. *Univ. of Wash. Med. Ctr. v. Wash. State Dep't of Health*, 164 Wn.2d 95, 102, 187 P.3d 243 (2008). Here, the certificate of need regulation at issue, WAC 246-310-270(9), sets forth the Department's methodology for evaluating proposed new ambulatory surgical facilities. The Department follows the regulation to the letter and does so consistently. Moreover, the Department's methodology is accurately designed to carry out the Department's policy regarding how many new operating rooms are needed and should be approved.

Was it therefore error for the Court of Appeals to conclude that the Department's statistical methodology is "biased toward need," and accordingly reverse the Department's determination that Swedish's proposed facility is needed, notwithstanding the deference that should have been given to the Department's interpretation of its regulation?

2. The Court of Appeals' Misinterpretation of WAC 246-310-270(9) Limits the Healthcare Options Available to Washington Citizens, Specifically Where and How They May Obtain Outpatient Surgical Procedures.

The Department has determined that Washington should have enough generally-available operating rooms to meet the total surgical need of the public. This policy goal is achieved through the methodology set forth in WAC 246-310-270(9). By following this methodology, the Department can accurately determine whether a planning area needs additional outpatient operating rooms. In some cases, the methodology has led the Department to conclude that a planning area has a surplus of operating rooms, and the application has been rejected; in other cases, the methodology has led the Department to conclude that a planning area has a shortage of operating rooms, and the application has been granted. This approach is even more appropriate today than it ever has been before, given the public's increasing need for outpatient surgical procedures. Approving less generally-available operating rooms than are needed to meet the total surgical need of the public would unduly limit where and how Washington citizens may obtain outpatient surgery in the future.

Was it therefore error for the Court of Appeals to reinterpret WAC 246-310-270(9) in a way that will severely restrict how many additional operating rooms may be built in Washington, especially given that the

Department's longstanding interpretation is consistent with both the purpose and the language of the regulation, and the Court of Appeals' new interpretation is consistent with neither?

These issues warrant review under RAP 13.4(b)(4), because they involve matters of "substantial public interest that should be determined by the Supreme Court."

D. Statement of the Case

1. East King County Needs More Outpatient Operating Rooms.

In recent years, there has been substantial population growth in East King County. This has been coupled with an increasing demand for outpatient surgical procedures nationwide, both in absolute terms and as a percentage of total surgeries. AR (1st) 140.[2] This trend is the result of several factors, including technological advances allowing more surgeries to be performed on an outpatient basis, and the preference of many patients to obtain surgery in an outpatient setting and closer to home. *Id.* A leading national survey has confirmed an "explosive growth of ambulatory surgery" across the U.S. AR (1st) 200.

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[2] The administrative record in this case is contained in two, separately-numbered parts. As it did in the Court of Appeals, Swedish will use "AR (1st)" to refer to the administrative record which preceded the first judicial review proceeding, and "AR (2d)" to refer to the additional administrative record on remand, which preceded the second judicial review proceeding.

As a result, there is now a substantial shortage of operating rooms on the Eastside. The Department projected a shortage of approximately 12 operating rooms by 2009 (including 5 outpatient operating rooms and 7 inpatient operating rooms). AR (2d) 265, 501. However, this is a *conservative* estimate. AR (1st) 2025. Swedish's calculations actually put the current deficit at 23 operating rooms (including 11 outpatient operating rooms and 12 inpatient operating rooms). AR (2d) 264.

2. Swedish Plans To Build a 5-OR Ambulatory Surgical Facility in Bellevue to Meet This Need.

Swedish is one of the largest and most respected healthcare providers in Washington. It operates three hospitals in Seattle, at its First Hill, Cherry Hill, and Ballard campuses. AR (1st) 133. On November 14, 2002, Swedish applied for a Certificate of Need ("CN") to establish a $7.4 million, 5-OR ambulatory surgery center ("ASC") in Bellevue, to better serve its Eastside patients and help meet the need for additional outpatient operating rooms in East King County. *See generally* AR (1st) 128-278 (CN application).

Swedish's Bellevue ASC would be open to all physicians in the community who have privileges to practice at Swedish, and would serve patients needing a diverse range of surgical procedures. AR (1st) 135-37. "Given the increasing emphasis on the provision of medical care in the

outpatient setting," as well as patients' increasing "preference to obtain services close to home," Swedish believes "that this ambulatory surgery center will allow for Swedish's medical services to be provided to [its] patients in a more appropriate and cost-effective manner." AR (1st) 135.

3. Swedish Must Obtain a Certificate of Need to Establish Its Bellevue ASC.

Before Swedish may establish its facility, it must obtain a CN from the Department. Under the CN statutory framework, "[t]he construction, development, or other establishment of a new health care facility" is subject to CN review. RCW 70.38.105(4)(a); WAC 246-310-020(1)(a). "Health care facility" is defined to include "ambulatory surgical facilities" such as the one Swedish seeks to establish in Bellevue. RCW 70.38.025(6); WAC 246-310-010(26); *see also* WAC 246-310-010(5) (defining "ambulatory surgical facility").

One of the CN criteria that Swedish must satisfy is "need" for the proposed facility. *See* WAC 246-310-210. For ASCs, the Department has adopted a statistical methodology for projecting future need for additional operating rooms. *See* WAC 246-310-270 (Ambulatory Surgery). Operating-room need is calculated for the specific geographic area, or "secondary health services planning area," in which the proposed ASC

will be built. *See* WAC 246-310-270(2). In this care, the relevant planning area is East King County. *See* WAC 246-310-270(3).

4. The Department of Health Approved Swedish's Bellevue ASC.

Respondents, Bellevue-based Overlake Hospital ("Overlake") and Kirkland-based Evergreen Healthcare ("Evergreen") have opposed Swedish's efforts to establish an ASC on the Eastside from the time Swedish filed its application. Under the original schedule for the facility, Swedish expected to treat its first patient on January 1, 2004. AR (1st) 138. Respondents' legal challenges have delayed the opening of Swedish's facility by more than five years now. However, Swedish's application ultimately was approved by the Department on November 9, 2006. AR (2d) 491-509.

5. Following A Judicial Review, the Superior Court Affirmed the Department's Approval of Swedish's Facility.

Overlake and Evergreen sought judicial review of the Department's decision in King County Superior Court, where the Department's approval of Swedish's facility was affirmed by the Honorable Julie A. Spector on August 23, 2007. CP 403.

6. The Court of Appeals Reversed the Department's Approval of Swedish's Facility.

Overlake and Evergreen next appealed the Department's decision to the Washington Court of Appeals, Division I. On October 13, 2008, the Court of Appeals reversed the Department's approval of Swedish's facility. On December 29, 2008, the Court of Appeals denied the motion for reconsideration filed by the Department and Swedish. The basis for the Decision is what now necessitates Supreme Court review.

The Department ordinarily will not approve a new ASC unless the Department projects a shortage of available operating rooms in the planning area. *See* WAC 246-310-270(4). The Department's methodology for projecting operating room need is set forth in WAC 246-310-270(9). There are essentially three steps in the methodology: (1) calculate the "existing capacity" of operating rooms in the planning area; (2) calculate the "future need" for operating room capacity in the planning area; and (3) determine whether the "future need" for operating room capacity is greater than or less than the "existing capacity." *See* WAC 246-310-270(9). If the "future need" for operating room capacity is greater than the "existing capacity," then new operating rooms are needed in the planning area.

Not all new ASCs require CN approval, however. The regulations specifically carve out an exemption for facilities "in the offices of private physicians or dentists, whether for individual or group practice, if the privilege of using the facility is not extended to physicians or dentists outside the individual or group practice." WAC 246-310-010(5). In other words, if an individual physician or group of physicians wish to have an operating room in their own office, and nobody other than the individual physician or group will be permitted to use the operating room, they do not need to obtain a CN to do so. These closed, private-practice facilities are frequently referred to as "CN-exempt" ASCs.

The Court of Appeals' reversal was based on how CN-exempt ASCs are treated within WAC 246-310-270(9). Specifically, the Department's methodology *includes* the surgeries performed in CN-exempt ASCs in its "use rate" calculation to determine the number of surgeries that will be needed; however, the Department does *not* include CN-exempt ASCs themselves in existing capacity. This is because the Department's methodology is designed to approve enough generally-available operating rooms to meet the total surgical need of the public in the future.

The Department's approach is correct under WAC 246-310-270(9). Indeed, it is mandated by the language of the regulation. *See*

Motion for Reconsideration (October 27, 2008) at 7-13 (detailed discussion regarding treatment of CN-exempt ASCs within the regulations). Moreover, there is nothing inconsistent about this approach. It is an accurate methodology for achieving the Department's stated policy goal.

The Court of Appeals rejected the Department's interpretation. It concluded that the Department's methodology is "flawed" and "biased towards need" and will therefore result in an "over-calculation of future need" and too many new facilities being approved. Decision at 1-2 & 6. To reach the correct outcome on ASC applications, the Court of Appeals concluded, the Department must either include CN-exempt ASCs in existing capacity, or exclude the surgeries in those facilities when determining the planning area's use rate. *Id.* at 3-6.

The Court of Appeals did not accord the Department's interpretation "substantial deference." Indeed, the Court of Appeals does not appear to have afforded the Department's interpretation any deference at all.

Moreover, the Court of Appeals' conclusion that the Department's methodology is "flawed" appears to be based on a misunderstanding of how the methodology works. This is illustrated by the fact that the Court of Appeals could "envision no scenario where the Department's

application of the formula will *not* result in a showing of need (except where there are no exempt facilities)." Decision at 4 (emphasis added). Both the facts of this case, as well as the Department's decisions on other CN applications for proposed ASCs, demonstrates that the Court of Appeals' understanding is wrong.

For example, the Department's 2006 *approval* of Swedish's application to build an ASC in Bellevue (in the East King planning area) can be compared with the Department's 2007 *rejection* of MultiCare Health System's ("MultiCare") application to build an ASC in Gig Harbor (in the Central Pierce planning area). The Department applied the same methodology in both cases, yet concluded that there was a shortage of operating rooms in East King (leading to the Department's approval of Swedish's application), but there was a 23-OR surplus of operating rooms in Central Pierce (leading to the Department's rejection of MultiCare's application). These outcomes are not surprising, given that East King has a much larger population than Central Pierce (500,000 people vs. 300,000 people) yet far fewer operating rooms (33 ORs vs. 59 ORs). In short, the Department's methodology did its job: more operating rooms were approved for the planning area with the shortage, but not for the planning area with the surplus. *See* Motion for Reconsideration (October 27, 2008) at 4-6 (detailed discussion of this comparison).

As a result of the Decision, the Department is no longer permitted to follow its longstanding interpretation of WAC 246-310-270(9), which has led to accurate determinations of operating-room need throughout Washington for many years. Now, the Department has no viable methodology for evaluating certificate of need applications for new ambulatory surgical facilities.

E. Argument Why Review Should Be Accepted

1. The Court of Appeals' Decision Changed Washington Certificate of Need Law.

The Department's longstanding interpretation of WAC 246-310-270(9) has been consistently applied to numerous certificate of need applications throughout Washington. AR (1st) 2023; AR (2d) 504. Nevertheless, the Court of Appeals' interpretation of the regulation, not the Department's, is now the controlling one—and the rules have therefore been changed regarding when new ambulatory surgical facilities will be built and where.

This is not a case in which a lower court's error affects only one applicant for one certificate of need. To the contrary, there is no dispute that the Department interpreted and applied the regulation for Swedish exactly as it does for every other applicant. The Decision therefore reverses the Department's approach to *all* applications for new ambulatory surgical facilities.

Swedish does not expect that Respondents will contest the impact of the Decision. Indeed, Overlake and Evergreen argued that the Decision ought to be published because it "is the first appellate interpretation of the need methodology found in WAC 246-310-270(9)" and it "rejected" the Department's longstanding interpretation and application of that regulation. *See* Motion to Publish (October 28, 2008) at 2. Because the Decision was "a significant correction to the Department's previous interpretation of the Methodology," Overlake and Evergreen argued, it "meets the second requirement of RAP 12.3(d)" (the decision modifies, clarifies or reverses an established principle of law). *See id.* at 3.

Outpatient surgery is an increasingly important part of Washington's healthcare system. The Decision changed the law regarding when and where new ambulatory surgical facilities will be approved. Given the substantial public interest at stake, it is important that the Supreme Court grant review, in order to resolve how WAC 246-310-270(9) should be interpreted.

2. The Court of Appeals Did Not Defer to the Department's Interpretation of Its Regulation.

Following oral argument in the Court of Appeals, this Court issued its decision in *University of Washington Medical Center v. Washington State Department of Health*, 164 Wn.2d 95, 187 P.3d 243 (2008).

Swedish provided a copy of the opinion to the Court of Appeals as a supplemental authority. *See* Swedish's Statement of Additional Authority (July 14, 2008).

In *University of Washington*, this Court reaffirmed that "in certificate of need cases" courts must accord "substantial deference" to the Department's interpretation of its regulations, particularly where the Department's "special knowledge and expertise" are involved. *Univ. of Wash.*, 164 Wn.2d at 102. Notwithstanding that ruling, in this case the Court of Appeals afforded no real deference to the Department's interpretation of WAC 246-310-270(9). The Department's interpretation was consistent with the language of the regulation, to the letter, and also served the Department's policy goals, as explained by its analyst during the administrative hearing. Nevertheless, the Court of Appeals concluded that the Department's approach was "biased toward need" and accordingly struck it down.

Given the substantial public interest at stake, it is important that the Supreme Court grant review, in order to ensure that the Department's interpretation of its regulation is accorded the appropriate level of deference.

3. The Decision Infringes the Department's Authority Over Health Facility Planning in Washington.

The Court of Appeals' approach, which will limit the Department's ability to approve new ambulatory surgical facilities in Washington, infringes the Department's authority over health facility planning in Washington.

Respondents appear to agree that the Decision has a substantial impact on Washington's healthcare system. Overlake and Evergreen have stated that the Decision "has a significant impact on the public through other pending and future cases involving applications for certificates of need for ambulatory surgical centers" and "will have a direct impact on how the Department should correctly apply the Methodology to future certificate of need applications for ambulatory surgical facilities, which will affect the planning for ambulatory surgical facilities throughout the state." *See* Motion to Publish at 3-4. Overlake and Evergreen have further stated that the Decision "has a direct impact on an important aspect of health care planning in Washington, which satisfies the third criteria in RAP 12.3(d)" (decision is of general public interest or importance). *See id.* at 4.

Given the substantial public interest at stake, it is important that the Supreme Court grant review, in order to restore to the Department its authority over health facility planning in Washington.

4. The Decision Will Harm Washington's Citizens and Healthcare System Statewide.

Not only does this case raise legal issues which warrant Supreme Court review, but review is particularly appropriate here given the practical impact of the Decision: (1) reducing the number of ambulatory surgical facilities built in Washington in coming years, and (2) requiring Washington residents to obtain more outpatient surgeries in hospital settings rather than in outpatient settings, which will be the opposite of the nationwide trend of how ambulatory surgical services are being provided today.

First, the Decision will reduce the number of ambulatory surgical facilities which the Department may approve, because the Decision's interpretation of the regulation sets a higher bar for proving mathematical "need" for new facilities than the Department has historically deemed appropriate. This will have the corollary effect of reducing the number of certificate of need applications statewide, because providers will know that the bar has been raised and their proposed facilities would have a much lower chance of being approved.

The Decision may even result in already-approved facilities, which are currently in the planning stage, not being built. In their Motion to Publish, Overlake and Evergreen imply that the Decision should not only prevent Swedish from establishing an ASC in Bellevue, but should also prevent Proliance Surgeons, a large, nationwide surgical practice, from establishing its proposed, and currently CN-approved, ASC in Kirkland. *See* Motion to Publish at 3. By granting certificates of need to Swedish and Proliance, the Department has essentially determined that, all things considered, Eastside residents will be better served by having a Swedish ASC in Bellevue and a Proliance ASC in Kirkland than by not having these facilities built—indeed, that these facilities are needed given the rapid population growth on the Eastside in recent years. However, the Decision may now force the Department to reverse its decisions with respect to both of these facilities.

The reduction in the number of ambulatory surgical facilities built in Washington will have a deleterious effect on Washington's healthcare system. A national study conducted by Dr. Lola Jean Kozak, et al., and contained in the administrative record, documents that ambulatory surgery has been increasing nationwide both in absolute terms and as a percentage of total surgeries. AR (1st) 185 *et seq*. Thus, although need is growing for outpatient surgery, the Decision will make it more difficult to build

new facilities to meet this need in Washington. The Decision will also reduce patient choice, because Washington residents will have fewer options regarding where, and from which providers, they are able to obtain outpatient surgical services.

Second, the Decision will require Washington residents to obtain more outpatient surgeries in hospital settings. Because it will be much more difficult to obtain a certificate of need to open a freestanding, generally-available ASC, there will be a shift away from providing outpatient surgery in such facilities, back towards the "old" model of providing outpatient surgery in hospitals (as well as in closed, CN-exempt operating rooms by those surgeons who choose to build them within their own offices). Washington will therefore be moving backwards. While the rest of the country is moving towards providing a greater percentage of surgeries in outpatient settings, Washington will be moving towards providing a greater percentage of outpatient surgeries in hospital settings.

For example, Swedish performs more than 4,000 ambulatory surgeries annually in its Seattle hospitals. AR (1st) 139. Rather than beginning to provide outpatient surgery for its Eastside patients at an ASC in Bellevue, which would be desirable for a variety of reasons, one result of the Decision will be that Swedish will have to continue providing all of these surgeries in a hospital setting. The Decision will therefore have a

quantitative impact on how many healthcare facilities are built in Washington in the coming years, as well as a qualitative impact on how healthcare is delivered in Washington.

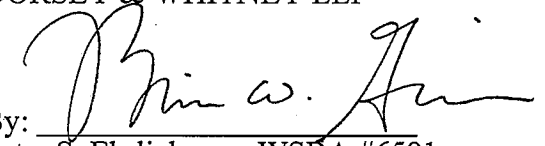
Given the substantial public interest at stake, it is important that the Supreme Court grant review, in order to avoid the harm that will be caused to Washington's healthcare system if the Decision is permitted to stand.

F. Conclusion

This Court should grant review to address the important administrative law issues identified above; to restore to the Department of Health its authority regarding how certificate of need applications will be evaluated and when new facilities will be approved; and to prevent the deleterious effects on Washington's healthcare system that will result from the Court of Appeals' Decision.

Respectfully submitted this 27th day of January 2009.

DORSEY & WHITNEY LLP

By: 

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PROOF OF SERVICE

Today I caused the foregoing PETITION FOR REVIEW BY THE SUPREME COURT OF WASHINGTON and attached APPENDIX to be served on the following persons by first-class mail:

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DATED this 27th day of January 2009.

Brian W. Grimm

Exhibit A

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

OVERLAKE HOSPITAL ASSOCIATION and OVERLAKE HOSPITAL MEDICAL CENTER, a Washington nonprofit corporation; and KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2, d/b/a EVERGREEN HEALTHCARE, a Washington Public Hospital District, Appellants, v. DEPARTMENT OF HEALTH OF THE STATE OF WASHINGTON, Respondent.	)	No. 60554-2-I DIVISION ONE UNPUBLISHED OPINION FILED: October 13, 2008

GROSSE, J. – Although a high level of deference is accorded to an agency's determination under the Administrative Procedure Act,[1] such deference will not lie where an agency's decision is based on an implausible interpretation of its regulations. Here, the Department of Health promulgated rules for determining whether a need exists for additional ambulatory surgical facilities in Bellevue that employ a flawed mathematical formula to establish the number of current and projected surgeries. That flawed formula included exempt surgical procedures in calculating demand, but excluded the facilities where exempt surgical procedures are performed from the calculation of existing capacity.

[1] RCW 34.05.570.

Hence, in an area where there is much private, exempt care, as Bellevue, the calculation will inevitably be biased toward need. Accordingly, we reverse the determination that Swedish Health Services could establish a five-bed ambulatory surgical facility on the eastside.

FACTS

The Washington Legislature enacted the State Health Planning and Resources Development Act in 1979, creating the certificate of need (CN) program to oversee health care development.[2] The CN program is an office within the Department of Health (Department) designed to effectuate the goals and principles of the Act. In order to establish or expand health care facilities, a provider must obtain a CN.[3] For that, a health care provider must establish a need for a particular health care service or facility in that health care planning area. CN applications are evaluated based on specific criteria set forth in the statute and applicable rules.[4]

To determine whether additional inpatient and outpatient operating rooms are needed in a health planning area, the Department uses the mathematical formula set forth in WAC 246-310-270(9). This formula is a means to compare current operating room capacity in a particular health planning area against anticipated future need, if any. Essentially, the methodology requires three steps:

- Existing Capacity: calculate the capacity of existing

[2] RCW 70.38.015(2).
[3] RCW 70.38.105; St. Joseph Hosp. v. Dep't of Health, 125 Wn.2d 733, 735, 887 P.2d 891 (1995).
[4] Chapter 70.38 RCW; WAC 246-310.

operating rooms in the planning area;

- Future Need: project the anticipated number of surgeries in the planning area three years into the future; and

- Net Need: calculate whether the existing operating room capacity is sufficient to accommodate the projected number of future surgeries. If not, then a need exists for more ambulatory surgical facilities in the planning area.

Here, the Department issued a CN to Swedish Health Services (Swedish) to establish an ambulatory surgical facility with five operating rooms in Bellevue. An ambulatory surgical facility is defined as "any free-standing entity, including an ambulatory surgery center that operates primarily for the purpose of performing surgical procedures to treat patients not requiring hospitalization."[5]

Evergreen Healthcare and Overlake Hospital Medical Center (collectively, Overlake) filed an objection to the issuance of the CN to Swedish alleging that there was no need for additional ambulatory surgical facilities in the area. The health law judge rejected Overlake's appeal, upholding the methodology employed by the Department in granting Swedish the CN. Overlake appealed to the superior court which upheld the health law judge. Overlake appeals.

ANALYSIS

Certain surgical facilities are exempt under the CN scheme. Exempt facilities include those located in the offices of private physicians that are unavailable for outside use. [6] In determining current operating room capacity under the Existing Capacity step, the Department does not include exempt

[5] WAC 246-310-010(5).
[6] WAC 246-310-010(5).

facilities where surgeries are currently performed. However, when computing whether additional operating rooms are needed under Future Need, the Department does include surgeries performed at exempt ambulatory surgical facilities. In short, the formula either undercounts the number of surgeries in the first step or over-counts the number of surgeries to be performed in the second step.

Overlake objects to the inclusion of surgeries at exempt facilities when the Department excludes those facilities to determine capacity. Both Existing Capacity and Future Need in the methodology use the terms "operating rooms" and "surgeries." As noted by the health law judge, the plain language of the governing WAC rule does not differentiate surgeries in exempt facilities from surgeries in nonexempt facilities. Nonetheless, the health law judge acquiesced in the Department's interpretation, permitting it to include surgeries performed at exempt facilities when calculating projected surgeries, but exclude those very same facilities when calculating the number of operating rooms needed to meet the demand for projected surgeries. Such an application makes no logical sense and is contrary to the basic canons of statutory interpretation. Indeed, we can envision no scenario where the Department's application of the formula will not result in a showing of need (except where there are no exempt facilities).

Testimony at the administrative hearing indicated that the Department's rationale for this unsound practice lay in the Legislature's policy directive to provide "accessible" health care. But, access to health care, though important,

was only one reason motivating the Legislature in creating the CN program. The Legislature's primary purpose was to control costs by limiting competition.[7] The Legislature clearly enunciated its goals in its declaration of public policy:

> That strategic health planning efforts must be supported by appropriately tailored regulatory activities that can effectuate the goals and principles of the statewide health resources strategy developed pursuant to chapter 43.370 RCW. The implementation of the strategy can promote, maintain, and assure the health of all citizens in the state, provide accessible health services, health manpower, health facilities, and other resources while controlling increases in costs, and recognize prevention as a high priority in health programs.[8]

As the Supreme Court in Saint Joseph Hospital v. Department of Health noted:

> While the Legislature clearly wanted to control health care costs to the public, equally clear is its intention to accomplish that control by limiting competition within the health care industry. The United States Congress and our Legislature made the judgment that competition had a tendency to drive health care costs up rather than down and government therefore needed to restrain marketplace forces. The means and end here are inextricably tied.[9]

The formula as interpreted and applied here by the Department is not particularly helpful in achieving any of these goals as it results in a formula that is fundamentally unsound. Sound reasoning requires the concomitant inclusion or exclusion of exempt facilities. To do otherwise defies logic and the plain meaning of the language used throughout the pertinent WAC.

On remand, the Department may very well come to the same conclusion it reached. Indeed, there is nothing that would prevent the Department from

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[7] RCW 70.38.015(1).
[8] RCW 70.38.015 (1) (emphasis added).
[9] 125 Wn.2d 733, 741, 887 P.2d 891 (1995).

discounting private surgical procedures and facilities entirely should it so choose. But here, the Department's decision to issue Swedish the CN was arbitrary and capricious because it was based on an erroneous interpretation of the governing statutes and a misapplication of its own regulations. The Department's calculation necessarily resulted in an over-calculation of future need for additional outpatient operating rooms in the East King County Planning Area. Because we find that the Department misapplied its own rule (WAC 246-310-270 (9)),[10] we reverse.

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[10] The WAC provides in pertinent part:

> (9) Operating room need in a planning area shall be determined using the following method:
>
> (a) Existing capacity.
>
> (i) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpatient surgery is ninety-four thousand two hundred fifty minutes. This is derived from scheduling forty-four hours per week, fifty-one weeks per year (allowing for five weekday holidays), a fifteen percent loss for preparation and clean-up time, and fifteen percent time loss to allow schedule flexibility. The resulting seventy percent productive time is comparable to the previously operating hospital commission's last definition of "billing minutes" which is the time lapse from administration of anesthesia until surgery is completed.
>
> (ii) Assume the annual capacity of one operating room dedicated to ambulatory surgery is sixty-eight thousand eight hundred fifty minutes. The derivation is the same as (a)(i) of this subsection except for twenty-five percent loss for prep/clean-up time and scheduling is for a thirty-seven and one-half hour week. Divide the capacity minutes by the average minutes per outpatient surgery (see (a)(vii) of this subsection). Where survey data are unavailable, assume fifty minutes per outpatient surgery, resulting in a capacity for one thousand three hundred seventy-seven outpatient surgeries per room per year.
>
> (iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.
>
> (iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour

Grosse, J

WE CONCUR:

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dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or minutes should also be excluded when calculating the need in an area. Exclude cystoscopic and other special purpose rooms (e.g., open heart surgery) and delivery rooms.

(b) Future need.

(i) Project number of inpatient and outpatient surgeries performed within the hospital planning area for the third year of operation. This shall be based on the current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.

(ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculation of (b)(iv) of this subsection.

(iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes."

(iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.

(c) Net need.

(i) If (b)(iv) of this subsection is less than (a)(iv) of this subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.

(ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of (b)(iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

Ellington, J. Becker, J.

Exhibit B

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

OVERLAKE HOSPITAL ASSOCIATION and OVERLAKE HOSPITAL MEDICAL CENTER, a Washington nonprofit corporation; and KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2, d/b/a EVERGREEN HEALTHCARE, a Washington Public Hospital District,

Appellants,

v.

DEPARTMENT OF HEALTH OF THE STATE OF WASHINGTON,

Respondent.

No. 60554-2-I

ORDER DENYING MOTION FOR RECONSIDERATION

The respondents, Department of Health of the State of Washington and Swedish Health Services, have filed a motion for reconsideration herein. The appellants have filed an answer to the motion. The court has taken the matter under consideration and has determined that the motion for reconsideration should be denied.

Now, therefore, it is hereby

ORDERED that the motion for reconsideration is denied.

Done this 29th day of December, 2008.

FOR THE COURT:

Grosse, J

Judge

Exhibit C

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

OVERLAKE HOSPITAL ASSOCIATION and OVERLAKE HOSPITAL MEDICAL CENTER, a Washington nonprofit corporation; and KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2, d/b/a EVERGREEN HEALTHCARE, a Washington Public Hospital District, Appellants, v. DEPARTMENT OF HEALTH OF THE STATE OF WASHINGTON, Respondent.	No. 60554-2-I ORDER GRANTING MOTION TO PUBLISH

The appellants have filed a motion to publish herein. The respondent, Swedish Health Services, have filed an answer to the motion. The court has taken the matter under consideration and has determined that the motion to publish should be granted.

Now, therefore, it is hereby

ORDERED that the motion to publish the opinion filed in the above-entitled matter on October 13, 2008 is granted. The opinion shall be published and printed in the Washington Appellate Reports.

Done this 30th day of December, 2008.

FOR THE COURT:

Grosse, J

Judge

Exhibit D

246-310-263 << 246-310-270 >> 246-310-280

WAC 246-310-270 No agency filings affecting this section since 2003

Ambulatory surgery.

(1) To receive approval, an ambulatory surgical facility must meet the following standards in addition to applicable review criteria in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240.

(2) The area to be used to plan for operating rooms and ambulatory surgical facilities is the secondary health services planning area.

(3) Secondary health services planning areas are: San Juan, Whatcom, East Skagit, Whidbey-Fidalgo, Western North Olympic, East Clallam, East Jefferson, North Snohomish, Central Snohomish, East Snohomish, Southwest Snohomish, Kitsap, North King, East King, Central King, Southwest King, Southeast King, Central Pierce, West Pierce, East Pierce, Mason, West Grays Harbor, Southeast Grays Harbor, Thurston, North Pacific, South Pacific, West Lewis, East Lewis, Cowlitz-Wahkiakum-Skamania, Clark, West Klickitat, East Klickitat, Okanogan, Chelan-Douglas, Grant, Kittitas, Yakima, Benton-Franklin, Ferry, North Stevens, North Pend Oreille, South Stevens, South Pend Oreille, Southwest Lincoln, Central Lincoln, Spokane, Southwest Adams, Central Adams, Central Whitman, East Whitman, Walla Walla, Columbia, Garfield, and Asotin.

(4) Outpatient operating rooms should ordinarily not be approved in planning areas where the total number of operating rooms available for both inpatient and outpatient surgery exceeds the area need.

(5) When a need exists in planning areas for additional outpatient operating room capacity, preference shall be given to dedicated outpatient operating rooms.

(6) An ambulatory surgical facility shall have a minimum of two operating rooms.

(7) Ambulatory surgical facilities shall document and provide assurances of implementation of policies to provide access to individuals unable to pay consistent with charity care levels provided by hospitals affected by the proposed ambulatory surgical facility. The amount of an ambulatory surgical facility's annual revenue utilized to finance charity care shall be at least equal to or greater than the average percentage of total patient revenue, other than medicare or medicaid, that affected hospitals in the planning area utilized to provide charity care in the last available reporting year.

(8) The need for operating rooms will be determined using the method identified in subsection (9) of this section.

(9) Operating room need in a planning area shall be determined using the following method:

(a) Existing capacity.

(i) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpatient surgery is ninety-four thousand two hundred fifty minutes. This is derived from scheduling forty-four hours per week, fifty-one weeks per year (allowing for five weekday holidays), a fifteen percent loss for preparation and clean-up time, and fifteen percent time loss to allow schedule flexibility. The resulting seventy percent productive time is comparable to the previously operating hospital commission's last definition of "billing minutes" which is the time lapse from administration of anesthesia until surgery is completed.

(ii) Assume the annual capacity of one operating room dedicated to ambulatory surgery is sixty-eight thousand eight hundred fifty minutes. The derivation is the same as (a)(i) of this subsection except for twenty-five percent loss for prep/clean-up time and scheduling is for a thirty-seven and one-half hour week. Divide the capacity minutes by the average minutes per outpatient surgery (see (a)(vii) of this subsection). Where survey data are unavailable, assume fifty minutes per outpatient surgery, resulting in a capacity for one thousand three hundred seventy-seven outpatient surgeries per room per year.

(iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.

(iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or minutes should also be excluded when calculating the need in an area. Exclude cystoscopic and other special purpose rooms (e.g., open heart surgery) and delivery rooms.

(b) Future need.

(i) Project number of inpatient and outpatient surgeries performed within the hospital planning area for the third year

of operation. This shall be based on the current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.

(ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculation of (b)(iv) of this subsection.

(iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes."

(iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.

(c) Net need.

(i) If (b)(iv) of this subsection is less than (a)(iv) of this subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.

(ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of (b)(iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

[Statutory Authority: RCW 70.38.135 and 70.38.919. 92-02-018 (Order 224), § 246-310-270, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-310-270, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 70.38.919. 90-16-058 (Order 073), § 248-19-700, filed 7/27/90, effective 8/27/90.]